

Volume: 4
Number: 3
Page: 925 - 940

Article History:

Received: 2022-11-03
Revised: 2023-03-14
Accepted: 2023-05-15

A CRITICAL REVIEW OF THE SUSTAINABILITY OF SOUTH AFRICA'S HEALTH SYSTEM, USER SATISFACTION AND KEY PERFORMANCE SCORES

Shenaaz GANI¹

¹University of South Africa, South Africa

Corresponding author: Shenaaz Gani

E-mail: harunamaama@gmail.com

Abstract:

The South African Government has made accessibility and equity the primary focus of its health policy objectives since 1994. However, the extent to which these policies achieve their aims of lessening inequality needs to be synthetically documented. This study critically reviews and synthesizes the literature on the nature of the South African health system, user satisfaction and critical performance scores. The study conducted a content analysis of several research papers and policy papers in the South African health sector. The review showed that the current health system is dualistic, indicating that the public health system needs to be living up to the National Core Scores. The evidence demonstrated ongoing discrepancies in access to and use of health services, notwithstanding legislative initiatives. It has negatively impacted households' satisfaction levels. Moreover, the review showed that users' perceptions of the quality of public healthcare services are deteriorating in South Africa. There is evidence of treatment delays, long waiting times, acute shortages of doctors, specialists and nurses, a lack of appropriate medication and poor health services delivery. The evidence provided about the South African health system can contribute to global policy discussions about health equity, the use of health services by households from different socioeconomic backgrounds, and how policies can increase access to quality Sustainability, Health System, Patient Safety, Leadership, Corporate Governance, Operational Management, National Core Standards health care for low-income households.

Keywords: Sustainability, Health System, Patient Safety, Leadership, Corporate Governance, Operational Management, National Core Standards.

Cite this as GANI, S. (2023). "A Critical Review Of The Sustainability Of South Africa's Health System, User's Satisfaction And Key Performance Scores." International Journal of Environmental, Sustainability, and Social Sciences, 4 (3), 925 - 940.



INTRODUCTION

The South African Government and other stakeholders have made some initiatives to improve and alter the country's health system, particularly access to health care and infrastructure. It has led to several health reforms, legislation passing, and policies (Lebese et al., 2018; Maseko & Harris, 2018). Enhancing the health system, which would extend to economic prosperity, is the primary goal of the health reforms. Due to this, numerous policy frameworks and techniques to accomplish this goal have been discussed (Belli et al., 2018). These actions and policies implemented by the South African Government are meant to improve and expand access to healthcare and the capacity of health practitioners. These policy frameworks and initiatives aim to achieve the South African Government's transformation goal (Maphumulo & Bhengu, 2019).

Another area for characterizing the primary healthcare dilemma in South Africa is inadequate capacity. Unusually, policymakers, management, healthcare professionals, associations, and healthcare consumers agree on the significance of reviving primary care. This consensus results from a shared understanding that healthcare delivery is the anchor of a country's prosperity and

literature. Given this delimitation, the study focused on South African health sector literature. The literature search started with a recent systematic literature review of the efficacy of primary care in South Africa to find relevant research to include in the study.

Several keywords, including the health system, patient safety, health leadership, health sector corporate governance, operational health management, national core standards, and South African health policies and regulations, among others, were used for the literature search. Then, starting with papers that focused on health system efficiency, the study looked for studies that had been published in the following databases: the Web of Science, Scopus, Emeralds, Elsevier and PubMed. Studies were considered as long as they addressed one or more of the definitions of the South African health system, assessed the effects on quality, outcomes, or costs, and presented or quoted original, peer-reviewed analyses. The study only referenced a portion of these publications to prevent repetition, selecting those that highlight ideas particularly relevant to the current policy recommendations while attempting to represent the documents consulted accurately. The reference list contains the complete list of the documents and publications that served as the foundation for the review.

RESULT AND DISCUSSION

An overview of the South African Health System. South Africa's public health sector is responsible for servicing around 84% of the population (NDoH, 2013a). However, there are concerns about the public health sector needing to be more funded and capitated, which has significantly affected the quality of health delivery in the sector (Docrat et al., 2019). The causes for the poor quality of health services are diverse and complex, and it is only through establishing a benchmark that quality can be assessed for creating room for improvement (Gilson et al., 2020). This paper proceeds by first defining the quality of health care. The paper defines quality in health care as the six dimensions of quality that can be intrinsically measured, as set out by the WHO in 2006 (Market al., 2010; NDoH, 2013a, p. 2). They are:

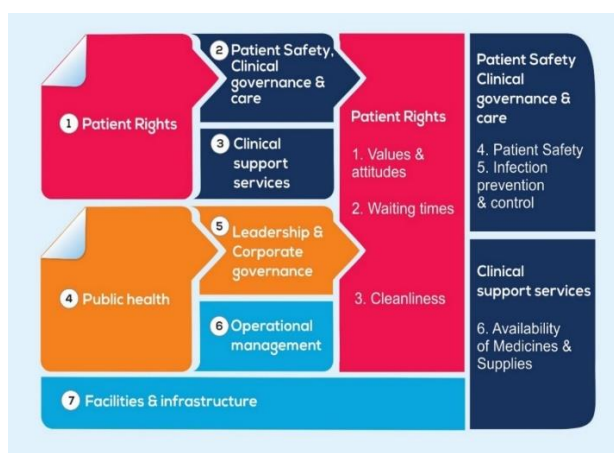
1. Safety: providing healthcare in a way that reduces user hazards.
2. Efficiency: providing healthcare services that minimize waste and maximize the utilization of limited resources.
3. Patient-centredness: Delivering healthcare that considers patients' preferences, rights and cultural variations.
4. Accessibility: prompt delivery of medical treatments while maximizing coverage.
5. Equity: Equity provides healthcare without regard to a person's gender, race, ethnicity, or socioeconomic standing.
6. Effectiveness: providing healthcare in a way that meets policy objectives and intended health effects.

Governments could better understand the idea of quality in healthcare thanks to the WHO's recommendations. Two different quality assurance systems have emerged globally to guarantee the quality of medical services. The first is governed by specific regulation, as practiced in the United Kingdom, where a regulatory body is established through law and given specific inspection and enforcement powers to regulate health facilities (NDoH, 2013a, p. 4). The second type of quality assurance system is more voluntary and informal, where health facilities voluntarily comply with accreditation and certification processes. This quality assurance system usually has no enforcement powers (NDoH, 2013a, p. 4). Government is responsible for the well-being of its citizens. Governments need to regulate the affairs of their country to protect their citizens from harm. Specific sectors may be regulated for specific reasons, the most pertinent of these being in the public's best interest. It is for this reason that the health sector is so highly regulated. By regulating the industry,

better healthcare quality can be attained (NDoH, 2013a, p. 4). The Office of Health Standards Compliance (OHSC), a body mandated to monitor and enforce compliance to ensure excellent health care, was established in South Africa as a result of the following significant changes:

1. In 2003, the National Health Act was passed. The Act offers the overall legal basis for a planned and standardized healthcare system. The Act specifies the rights and obligations of healthcare providers and users to ensure an improvement in the standard of healthcare; The Act called for the NDoH to establish an Office of Standards Compliance (OHSC, 2017:3).
2. The South African Policy on Quality in Health Care was issued in 2007. The significance of the Office of Standards Compliance in assessing the quality of healthcare services was reaffirmed in this paper (OHSC, 2017:3).
3. The Core Standards for Health Establishments were introduced in April 2008. It introduced a group of quality standards that are well-regarded and research-supported (OHSC, 2017:3).
4. The 10-Point plan was released in 2009, reiterating the government's dedication to providing high-quality healthcare (NDoH, 2013a, p. 8).
5. In January 2011, a revised set of National Core Standards (NCS) was published, and this set of evaluation instruments is extensively employed in the public sector to measure performance. A second subset of the NCS, consisting of the six areas of most serious patient concern, was developed and used in the baseline audit of all public health facilities during the 2011–12 fiscal year (OHSC, 2017:3).
6. The Negotiated Service Delivery Agreement (NSDA) between the President and the Minister of Health entitled “A Long and Healthy Life for all South Africans” was developed in 2011. Outcomes 2 and 4 specifically deal with health services reform (OHSC, 2017:3).
7. In August 2011, the Green Paper was published, the Policy Paper for NHI in South Africa (NDoH, 2013a, p. 10).
8. In 2017 the White Paper was gazetted and is now the NHI Policy Paper, the foundation of new health insurance.

The NCS describes the essentials for healthcare quality based on six quality elements: acceptability, safety, reliability, equity, accessibility, and efficiency. These elements are called the ministerial priority areas. These six ministerial priority areas are further grouped into seven domains. The six ministerial priority areas, primarily anchored in patient rights, clinical governance and care, and clinical support services, are shown graphically in Figure 1. The six aspects of quality inform these domains.



Source: OHSC 2017:4

Figure 1. Structure of the seven domains of the six ministerial priority areas

Figure 1 presents the structure of the seven domains of the six ministerial priority areas. The National Core Standards set the benchmark for high-quality medical care. These criteria are concentrated at the healthcare facility's level, where healthcare is provided. Patient rights, safety, clinical governance and care, and clinical support services are the first three domains, and they are all closely related to giving patients high-quality medical care (Mail & Guardian, 2012, p. 1). The remaining categories include operational management, public health, leadership and corporate governance, and facilities and infrastructure, which form the support network that would guarantee the availability of health care (Mail & Guardian, 2012, p. 1).

As a result of the above journey, the OHSC in South Africa was established in 2013 following the amendment to the National Health Act No. 61 of 2003, "to protect and promote the health and safety of people as the cornerstone of quality healthcare" (OHSC, 2017:3). The annual inspection report aims to determine compliance of public health facilities with the NCS and more specifically the core standards as depicted in Figure 1.

Since its inception, the reports produced by the OHSC have given details of the results of the inspections conducted over the years. These outcomes relate to applying clinical recommendations, procedures, efficient referral networks, and leadership and governance following NHI policy (OHSC, 2017:3). The 2016/17 yearly inspection report serves as an example of the work done by the OHSC. It noted gaps between the prescribed and actual situation. These gaps were similar to previous inspection reports. The report mentioned that governance structures could have been more effective, with a negative impact on leadership, and there needed to be more evidence of oversight, accountability and good management.

Public Health Expenditure, Access to Health Services and users' satisfaction The South African Government spent R15.6bn of its consolidated national and provincial budget on health in 1994/95. It represented 10.5% of its consolidated national and provincial budget spending and 3.5% of GDP (National Treasury, 1995). This amount increased by 1050% to R183bn in 2016/17 (DoH, 2015, p. 47). The increase amounted to 11.7% of the government's consolidated national and provincial budget expenditure. This reallocation of resources and increase in health spending suggests that South Africa needs to consider the value it is receiving for the money spent on health. Notwithstanding these increases, inequality is more significant today in South Africa than it was at the end of apartheid, as evidenced by the Gini coefficient (Deghaye, McKenzie & Chirawu, 2014:7). One reason is that, in 1990, when apartheid was ending, the health system was extended without increasing the capacity to close the inequality gaps in the distribution of health/social services and resources. To some extent, the introduction of PHC and system reform has contributed towards improving the health services for people experiencing poverty but still needs significant disparities between previously disadvantaged people (Burger, Bredenkamp, Grobler & Van der Berg, 2012).

In this respect, a two-tier health system still exists, whereby the government subsidizes the private sector through tax rebates and other hidden subsidies in the general training of doctors and other medical personnel (Obuaku-Igwe, 2015, p. 120). Following this, the White Paper presented two primary rationales for establishing National Health Insurance (NHI): the heavy burden of the disease plaguing the country and the structural problems in the health sector. A significant difference exists between the satisfaction levels of households receiving health care in the public and private sectors. The statistics released by StatsSA (2017b:21) in the GHS for 2017 indicated that just more than half of the households surveyed (55.1%) were very satisfied with their healthcare service received from public healthcare facilities. In contrast, Table 1 shows that 91.5% of households receiving healthcare services from the private sector were delighted (StatsSA, 2017b).

Table 1. Level of satisfaction with public and private healthcare facilities by province

Level of satisfaction with the healthcare institution	Province									
	WP	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Public Health Care										
Ve1y satisfied	48,3	59 1	49,7	48'1	46,9	46,7	55,8	62,3	75 1	55,1
Somewhat satisfied	22'1	30,2	28,8	23,0	34,0	27,6	26,8	24,2	14,9	26,7
Neither satisfied nor dissatisfied	11 3	4,6	7,6	10,9	12,5	7,2	8,7	5,3	4,2	8,4
Somewhat dissatisfied	6,8	3,8	4,8	9,5	3,2	6,4	3,9	4,3	4,1	4,5
Ve1y dissatisfied	11,5	2,3	9,1	8,6	3,4	12,1	4,9	4,0	1 7	5,3
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Private Health Care										
Ve1y satisfied	93,2	96,0	86,9	86,6	86,6	90,9	92,0	950	93,2	91,5
Somewhat satisfied	3,7	3,4	7,0	8,3	10,6	7,2	5,8	2,7	3,5	5,8
Neither satisfied nor dissatisfied	1,0	0,2	3,9	2,4	2,0	0,5	1,4	1,3	1 8	1,4
Somewhat dissatisfied	0,9	0,5	0,4	1 4	0,6	1,1	0,5	0,0	0,6	0,7
Ve1y dissatisfied	1,3	0,0	1,7	1 3	0,3	0,3	0,4	1,0	0,9	0,6
Total	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0

Source: StatsSA 2017b:23

Table 1 demonstrates that private medical aid coverage in the country was 16.9% of the population or 9.5 million people in 2017, and at least one member of a household belonging to a medical aid scheme, as depicted in Table 2 (StatsSA, 2017b, p. 24)

Table 2. Medical aid coverage, 2002-2017

Indicator (Numbers in thousands)	YEAR											
	2002	2004	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
The number covered by a medical aid scheme	7284	7268	8057	8502	8967	8312	9157	9608	9470	9307	9447	9475
Number not covered by a medical aid scheme	3844 5	3966 6	4126 6	4128 4	4160 6	4301 3	4281 9	4330 0	4394 6	4506 5	4564 6	4665 4
Sub-total	4578	4693 4	4932 2	4978 6	5057 3	5132 5	5197 6	5290 8	5341 6	5437 2	5509 3	5612 9
The percentage covered by	159	155	163	17.1	177	162	176	182	177	17.1	17.1	169

a medical aid scheme												
Do not know	140	58	101	19	23	0	58	36	46	71	53	24
Unspecified	53	57	56	347	254	249	291	161	541	308	474	369
Total	4592	4704	4947	5015	5085	5157	5232	5310	5391	5475	5562	5652
population	1	9	9	2	0	4	5	4	2	0	0	2

Source: StatsSA 2017b:24

However, the above is survey data, which, by its nature, tends to differ from actual numbers. For a more accurate depiction of the number of people who had access to private healthcare services, the Council for Medical Schemes (CMS) data was consulted. According to the CMS 2018-19 Annual Report, there were 4.039 million principal members of medical schemes and 8.916 million beneficiaries. It is less than the numbers of StatsSA. Thus, the public health system is responsible for more people than suggested by the survey. Nevertheless, it should keep the proportionate satisfaction levels the same as the difference is not substantial, that is around 600000 people.

Performance scores of the South African Health System according to the NCS's six priority areas South Africa has around 3200 public clinics, 325 public hospitals and 324 community health centers (OHSC, 2017:10). These health service providers provide health services to citizens. It was made evident during a regular inspection conducted by the OHSC. For instance, the latest inspection conducted by the OHSC was in the 2016/17 financial year. The inspection provided the following facts: 649 (17%) public health facilities were inspected to monitor compliance with the NCS. According to the OHSC, facilities inspected should score at least 80% to be accredited facilities with an acceptable level of care. The inspection further provided some facts about the quality of health services in the various provinces. For instance, only two of the 59 Limpopo clinics inspected scored over 50%.

In the Eastern Cape, only 12 of the 100 clinics inspected achieved over 50%, with the remaining clinics scoring between 30% and 39% (Cullinan, 2017, p. 1). Similarly, of the 53 clinics inspected in the Free State, only five scored over 50%. The following paragraphs discuss the findings of the OHSC according to the six priority areas identified by the NCS. The OHSC reported individually on the performance scores of each of the nine South African provinces, distinguishing between hospitals, community health centers and clinics. Overall, hospitals had higher average performance scores than community health centers and clinics (OHSC, 2017:18). Table 3 lists the scores for the six NCS priority areas.

Table 3. Six Ministerial Priority Areas

Priority Area	Percentage range for different provinces
Availability of medicines and supplies	47% to 69%
Cleanliness	46% to 55%
Patient safety	45% to 60%
Infection prevention and control	51% to 59%
Values and attitudes of staff	56% to 66%
Waiting times	64% to 68%

Source: OHSC 2017:18

Availability of medicines and supplies. An essential supply in any health center or hospital is medicine. A lack of it can be disastrous as patients may not receive the needed care. However,

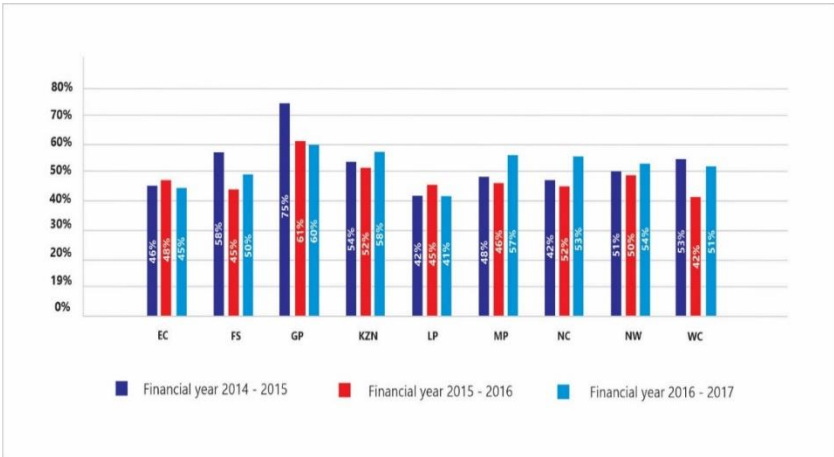
there have been reports of nonavailability of medicines and supplies at these health facilities. According to a former head of a trauma unit in one of the hospitals, *"Government hospitals often ran out of pain-killing drugs...one day we ran out of Panado, so we had to use morphine even on small babies"* (Kane-Berman, 2014, p. 4). Confirming the claim by the head of the trauma unit, the Stop Stockouts Project, run by a civil society organization, also conducted a national survey in 2015 that revealed that stockouts had increased from 2014 to 2015 (Stop Stockouts, 2015, p. 1). The 2015 report indicated that one in three facilities was affected by ARV or TB medicines stockouts in the three months before the survey. Table 4 shows the percentage of facilities, according to province, reporting at least one ARV or TB medicine stockout in the three months before the survey for 2013–2015.

Table 4. Percentage of Facilities Reporting at Least One ARV or TB Medicine Stockout

Province	Facilities reporting at least one ARV or TB medicine stockout		
	% (n/N)		
	2013	2014	2015
Eastern Cape	20% (89/447)	28% (141/509)	32% (148/465)
Free State	54% (90/167)	28% (41/147)	53% (71/135)
Gauteng	20% (58/284)	25% (71/283)	56% (157/278)
KwaZulu-Natal	14% (45/322)	19% (83/436)	26% (108/417)
Limpopo	41% (989/218)	29% (77/266)	25% (63/248)
Mpumalanga	26% (58/224)	40% (82/205)	74% (163/220)
Northern Cape	18% (11/62)	21% (23/107)	23% (28/123)
North West	4% (8/ 182)	39% (86/222)	41% (92/223)
Western Cape	5% (11/223)	4% (10/279)	12% (32/261)
South Africa	21% (459/2 139)	25% (614/2 454)	36% (862/2 370)

Source: Stop Stockouts 2015:2

The evidence in Table 4 demonstrates that the overall stockout has increased since 2014 from 25% to 36% in 2015. The increase was partially attributed to a widespread national stockout of adult ART products during the survey period (Stop Stockouts, 2015, p. 2). According to the 2016/17 Office of Health Standards report, there was no significant improvement in the availability of medicines and supplies from 2014 to 2017. Figure 2 shows the availability of medicines and supplies. The improvement across provinces has yet to be demonstrated.



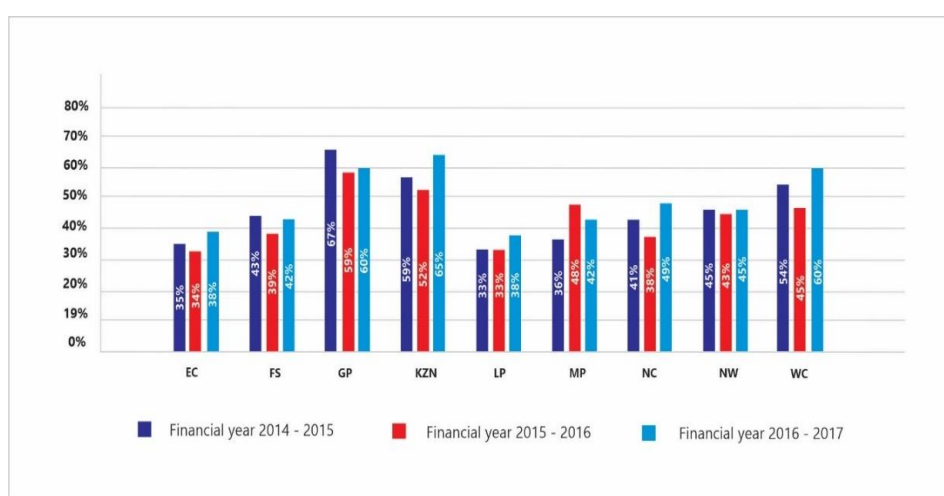
Source: OHSC 2017:19

Figure 2. Availability of medicines and supplies scores per province from 2014/15 to 2016/17

Medication stockout problems are aggravated by the persistent failure to pay suppliers. The problem of non-payment has also impacted staffing, and there have been significant losses in nursing staff (Kalonji & Mahomed, 2019). The National Health Laboratory Service (NHLS), responsible for HIV and TB testing and cancer screening in the public health system, was in a critical condition in 2015 due to the outstanding funds owed by provincial administrations. With diagnostic facilities, doctors can treat and medicate patients. It was also understood that the NHLS was "lacking skilled staff" such as pathologists with extensive experience who were demoralized by the situation and being replaced by young inexperienced personnel (Bhekisisa, 2015; Beli et al., 2018).

Treatment delays have been a common problem, which is still unresolved. In 2017, the Chris Hani Baragwanath Hospital in Soweto had a backlog of thousand patients waiting for various medical procedures. Mrs. Kubheka, a 55-year-old female, was advised in February 2017 that she would have to wait seven years for hip replacement surgery. There was also a backlog of 26 000 surgeries in Limpopo, and patients diagnosed with cancer needed to wait 12 months from diagnosis to start treatment (Wilson, 2018). This information paints a gloomy picture of the South African health system. Clinical support services are necessary to provide clinical care, such as ensuring the timeous availability of medicines and efficient provision of diagnostic, therapeutic and other support services.

Cleanliness. Hospitals continue to get media complaints about the state of cleanliness of facilities regularly. According to reports, many hospitals and clinics are perceived by patients and users as being unclean, disorganized, and unsanitary (NDoH, 2013a, p. 16). The unhygienic health environment may lead to infections associated with health care, which could compromise the health outcomes of the patients. These observations are reflected by the 2016/17 OHSC report results. Figure 3 shows the cleanliness priority area scores by province. Figure 3 demonstrates that Gauteng and KwaZulu-Natal had the highest cleanliness priority scores compared to other provinces (OHSC, 2017:20).



Source: OHSC 2017:20

Figure 3. Cleanliness Scores Per Province from 2014/15 To 2016/17



Patient Safety. The research titled "Saving Babies" by the Medical Research Council was published in May 2015. It tracked the number of live births, neonatal fatalities, and reasons for newborn mortality in South African healthcare facilities between January 2012 and December 2013. According to the research findings, more than 80 000 infant deaths were recorded in 588 public facilities over two years (MRC, 2015). Another incident pointing to a lack of attention to the safety of patients is when on 2 March 2017, the roof at the entrance to Charlotte Maxeke Academic Hospital in Johannesburg collapsed. Two people were trapped under the rubble, and five sustained minor injuries (Khoza, 2018). The Life Esidimeni disaster, during which 144 people died, also highlights the issue of patient safety within the public health sector. This tragedy's positive outcome is its extensive coverage, highlighting the need for patient safety (Zille, 2018).

These previous incidences show continued poor management in the public health sector, highlighting how the healthcare system is being destroyed. It draws attention to the appalling disrepair of many hospital buildings, where elevators break down regularly, and patients must be carried up and down the stairs on stretchers. Renovations, if initiated, are "often halted midway without any explanation," and the works are usually "amateurish and sub-standard" (GroundUp, 2017).

Infection Prevention and Control. Regarding infection prevention and control in the South African health system, the OHSC noted the following deficiencies per the 2016/17 inspection; Hospitals are not providing isolation facilities for infectious and communicable diseases, which impacts patient safety. There were no policies or procedure manuals relating to the isolation of patients; There was no evidence of hand washing campaigns; There was no evidence of educational material for staff and patients regarding common healthcare-associated infections; Educational material relating to specific infections such as swine flu, cholera and Methicillin-resistant *Staphylococcus aureus* (MRSA) was not available (OHSC, 2017)

Values and Attitudes. The values and attitudes of health workers are the personifications of any health system (WHO, 2015). It has been accepted by politicians and health managers alike, and if the human resources being applied in health do not improve, the overall performance in health will not improve. Since 1994 there have been several positive initiatives to address this element of health, including financial incentives offered to those engaged in public health. Unfortunately, the roll-out of these initiatives has been hampered by implementation flaws (Gray & Vawda, 2016).

The Human Resources for Health (HRH) strategic plan was formulated in 2011 and concedes that the human resource element of health requires much attention (DoH, 2011a, p. 7). The values embedded in the Human Resources for Health (HRH) strategic plan include the need to; Provide patient-centered quality health care; Ensure universal coverage and universal access to health care; and Enable an innovative and caring environment for health professional development and patient care (DoH, 2011a, p. 76).

The HRH strategic plan also acknowledges that the attitudes of healthcare providers need to be determined, and the document proposes an audit of attitudes (DoH, 2011a, p. 113). Illegal labor strike action by healthcare workers and nurses also creates the impression of an absence of care for patients and speaks to the attitudes of the healthcare workers and nurses. News 24 reported in 2017 that the Gauteng health department had paid more than R1 billion to settle 185 medical negligence cases since January 2015. In addition, another 51 cases before the court were expected to claim some R414 million. Babies with brain damage accounted for 76% of these claims (Raborife, 2017).

The annual report by the DoH for the 2016/17 year indicated that R13.4 billion had been allocated to medico-legal liability, which represents a growing portion of the department's budget that could be better spent on providing quality care. According to the then Gauteng Health MEC Gwen Ramokgopa, the more disturbing revelation was that none of the staff members involved in

the negligence cases had been disciplined (Raborife, 2017). This lack of accountability is further evidence of a failing public health system, and these failures would need to be corrected as the first step toward achieving UHC.

Waiting times. An unequal distribution of health professionals across the various provinces plagues the South African health system. The unequal distribution of health services across the country is evidenced by the 33 specialists per 100 000 residents in the Western Cape compared to 1.3 specialists per 100 000 in Limpopo. According to the GroundUp (2017b) report issued in November 2017, the state of clinics in East London was cause for concern. After receiving complaints from community members, GroundUp decided to investigate the Newlands Clinic, which is responsible for servicing close to eight villages in Nxarhuni outside Mdantsane in East London. The investigation revealed that the registration of patients was done in a tent that was not insulated against rain or severe heat. The day the clinic was visited, only one nurse was on duty. One patient who arrived before 07:00 had to walk five km to the clinic. There was no certainty that he would be attended to that day, even though he was only there to take his treatment and did not require the nurse's service.

The second visit to the clinic a week later also found only one nurse on duty, and it was an icy cold and windy day which was not made any easier by the tent. In addition, there was no electricity or running water available at the clinic that day, and patients had to relieve themselves in pit toilets. A doctor is only available at the clinic twice a month, and if communities desperately need the services of a doctor, they need to travel to Mdantsane, and transport money is required (GroundUp, 2017b). The 2017 report by the OHSC noted that patient privacy needed to be maximized in the provision of care, specifically where doors, screens and curtains would be left open while attending to patients. It points to patients being treated without respect and care. There needed to be more patient rights, and posters and help desks were not available at the entrance of hospitals.

Leadership and Corporate Governance. Damage to the leadership and corporate governance applicable to the public health sector came in several forms and ways. One example is then President Thabo Mbeki's refusal to acknowledge the growing HIV/AIDS pandemic and dismiss the use of ARVs. This denialist response compounded the burden of the disease. It served as one reason for the exodus of medical professionals from the public sector into the private sector or through emigration. This decision demoralized health personnel and further pressured those who remained in the public sector.

A further indication of the lack of trust in the government's ability to lead and govern is found in the Free Market Foundation's statement on NHI: "The NHI will act like a huge medical scheme. When compared to the Compensation Fund, which currently receives about R8-billion a year in income and has R52-billion in assets, most of which is administered by the Public Investment Corporation (PIC), which employs 1,630 people and last year [2015], paid out R1.4-billion in medical claims, the NHI budget is 32 times larger, total claims payable are likely to be 100 times more, not including paying suppliers, and it will need between 52,000 and 160,000 employees. If the government cannot run an R8-billion fund efficiently, how will it manage an R256-billion fund? The famous US satirist PJ O'Rourke summed up the situation succinctly when he said, "If you think healthcare is expensive now, wait until you see what it costs when it is free" (Free Market Foundation, 2016:1)

Operational Management. Government is resolute about pursuing affirmative action policies and cadre deployment, implying that public sector appointments are based on "race and political allegiance to the ruling party" (Kane-Berman, 2014, p. 2). It is essential to understand that this is the government's policy and that the required skills and experience would be considered secondary in



making an appointment. It does not mean that all public health personnel are unqualified, but a substantial number are (Kane-Berman, 2014, p. 2).

According to Kane-Berman (2014:3), the lack of accountability has become a part of the political culture in South Africa: “people who fail to do their jobs because they know they can get away with it” (Kane-Berman, 2014, p. 3). *The Lancet* series on health had this to say about the poor management in the public health sector: Poor leadership and stewardship (taking responsibility) run like ruinous cancer through the public health care system. Post 1994, many inexperienced managers were placed in positions of seniority and have struggled to deal with significant challenges, particularly human resource management. Incompetence within the public sector is widespread, and the government needs more political will to manage underperformance in the public sector. Loyalty rather than the ability to deliver has been rewarded. Leaders and managers have not been held accountable when mistakes have been made. Without concerted efforts to change national thinking on accountability, South Africa will become a country that is not just a product of its past but one that is continually unable to address the health problems of the present or to prepare for the future (Chopra et al., 2009, p. 1027)

Gross inefficiencies in the public healthcare sector are not going unnoticed. The report released on 21 June 2018 by a particular investigating unit (SIU) about the corruption in the Department of Health (DOH) between January 2006 and May 2010 revealed gross mismanagement and abuse of power. Despite the report being finalized in February 2017, it was withheld as the SIU implicated 12 public servants and politicians in corruption, fraud, irregular, fruitless and wasteful expenditure, financial misconduct, and irregular procurement (Cokayne, 2018, p. 1). R1.46 million had been spent on irregular, fruitless and wasteful expenditure. In contrast, the irregular expenditure, fraud and financial misconduct relating to developing a turnaround strategy amounted to losses of R329.7 million. The losses relating to irregular, fruitless and wasteful procurement amounted to R2.1 million—a further R299.46 million related to irregular procurement (Cokayne, 2018, p. 1).

A letter written to the then provincial premier Ace Magashule by some doctors working in public health facilities in the Free State in 2015 explains the “constant shortage of even the most basic medications and consumables” and the impact of this on staff carrying out their duties. In the Dihlabeng Hospital, around “300 patients on a waiting list for spectacles, but [could not] get it due to lack of funds”. Problems and issues listed included the ambulance crisis, the capped x-ray services, and doctors needing to be employed but unnecessary management positions being created (GroundUp, 2017a).

Discussion and Policy Implications. The literature review showed that adequate healthcare as a direction of health systems and as a set of health services provided in South Africa could enhance quality, outcomes, and cost of care. The evidence favors measures that improve infrastructure and service delivery and enhance practitioners' capacity to carry out their duties and realign health systems. There are various measures in the Policy Paper for NHI in South Africa, the Negotiated Service Delivery Agreement (NSDA) and the Core Standards for Health Establishments that are meant to strengthen primary care. These policies and frameworks hoped that the primary care workforce would be increased, primary care practitioners will be given new skills, and the current delivery system would be reoriented through organizational and payment reforms. The analysis of the evidence backs initiatives to improve providers' capacity to provide primary care services and to refocus health systems on primary care. There is less proof, though, that broadly expanding the number of South African doctors can improve health outcomes and slow healthcare spending growth unless these initiatives are effective. The evidence supports the expansion and ongoing review of the initiatives already in place to equip health professionals better to perform essential primary care functions. Payment reform (for instance, lessening the importance of fee-for-service payments), in-kind support (for instance, continued investment in health information

technology), and technical help (for instance, a primary care "extension service") are all examples of policy interventions that are needed.

Increasing the quantity of primary care-trained physicians will be necessary to redirect the healthcare system. The public's perception of primary care needs to be improved. Capital investments need to be redirected away from high-tech procedural services with little impact on population health and toward community-based primary care. Communication between specialists and primary care providers needs to be improved. All these factors contribute to meaningful system-level change. Additionally, even if the workforce is reluctant to adapt, payment reforms to lessen the importance of 'cash and carry' payments and close the pay gap between cognitive and procedure-based services may contribute significantly to reorientation.

The analysis of the evidence indicates that these systems have a significant impact on patient care. The debate shows that despite policy interventions resulting from the reform, the long-established characteristics of the health system are likely to shift towards primary care slowly, even with significant incentives. Increasing the number of primary care professionals may lose a significant opportunity to enhance the quality of health care delivery in South Africa without focused measures to reorient local health systems and improve the capabilities of primary care professionals. The determined pursuit of primary care as a health systems approach, on the other hand, is expected to positively affect the quality, outcomes, and cost of healthcare in South Africa, according to the available research.

CONCLUSION

The degree to which the various health policies and frameworks in South Africa have succeeded in reducing inequality has yet to be discovered and synthetically documented. This study reviewed existing literature to evaluate the state of the health system in South Africa. This study aimed to examine the nature of healthcare delivery in South Africa. The state of the South African health system was assessed by researching the performance according to the six priority areas and other performance scores. These priority areas comprised safety, efficiency, patient-centredness, accessibility, equity and effectiveness. The study performed a document analysis of research publications and policy documents in the South African health industry was done for the study. The evaluation revealed that the present health system needs to catch up to the National Core Scores and has a detrimental effect on household satisfaction levels. The results showed that, despite legislative efforts, there still needs to be more disparities in access to and use of health care. The review also revealed that users' opinions of South Africa's public healthcare systems are worsening. There is proof of treatment delays, lengthy wait times, severe shortages of physicians, specialists, and nurses, a lack of the proper medications, and subpar delivery of healthcare services. The information offered regarding the South African healthcare system can help inform talks about health equality, including how households from various socioeconomic backgrounds use healthcare services and how policies can make it easier for low-income households to get high-quality healthcare.

REFERENCE

- Belli, P., Matsebula, T., Ndhlalambi, M., & Ngarachu, M. (2018). A Brief Profile of the Status of Health and the Health System in South Africa. *The World Bank Group*, 1-15.
- Bhekisisa. (2015, 9 January). A crisis in the laboratory threatens the nation's health. Bhekisisa Centre for Health Journalism. <http://bhekisisa.org/article/2015-01-09-crisis-in-laboratory-threatens-the-nations-health>



- Burger, R., Bredenkamp, C., Grobler, C., & Van der Berg, S. (2012). Have public health spending and access in South Africa become more equitable since the end of apartheid? *Development Southern Africa*, 29(5), 681-703.
- Chopra, M., Lawn, J. E., Sanders, D., Barron, P., Karim, S. S. A., Bradshaw, D., Jewkes, R., Karim, Q. A., Flisher, A. J., Mayosi, B. M., & Tollman, S. M. (2009). Achieving the health Millennium Development Goals for South Africa: Challenges and priorities. *The Lancet*, 374(9694), 1023-1031.
- Cullinan, K. (2017, 18 April). Health-e: Grim findings after health facilities are inspected. *Daily Maverick*. <https://www.dailymaverick.co.za/article/2017-04-18-health-e-grim-findings-after-health-facilities-are-inspected/>
- Deghaye, N., McKenzie, T., & Chirawu, P. (2014). Inequality in South Africa: A two-part document on the current understanding and dimensions of inequality in health, gender and livelihoods. Occasional Paper No. 4. University of KwaZulu-Natal.
- Department of Health. (2011a). Human Resources for Health in South Africa – HRH Strategy for the Health Sector 2012/13–2016/17. *National Department of Health*.
- Department of Health. (2011b). National health act (61/2003): Policy on National Health Insurance. Government Gazette 34523. *National Department of Health*.
- Department of Health. (2017). National health act, 2003: National Health Insurance Policy – Towards universal health coverage. https://www.gov.za/sites/default/files/gcis_document/201707/40955gon627.pdf
- Docrat, S., Besada, D., Cleary, S., Daviaud, E., & Lund, C. (2019). Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy and Planning*, 34(9), 706-719.
- Friedberg, M. W., Hussey, P. S., & Schneider, E. C. (2010). Primary care: A critical review of the evidence on quality and health care costs. *Health Affairs*, 29(5), 766-772. <https://doi.org/10.1377/hlthaff.2010.0025>
- Gilson, L., Ellokori, S., Lehmann, U., & Brady, L. (2020). Organizational change and everyday health system resilience: Cape Town, South Africa lessons. *Social Science & Medicine*, 266, 113407.
- Gray, A., & Vawda, Y. (2016). Health Policy and Legislation. In A. Padarath, J. King, E. Mackie, & J. Casciola (Eds.), *South African Health Review* (pp. 27-39). *Health Systems Trust*. <http://www.hst.org.za/publications/south-african-health-review-2016>
- GroundUp. (2017a). How the Free State health system is being destroyed. <https://www.groundup.org.za/media/features/freestate>
- GroundUp. (2017b, November 17). Vital Eastern Cape Clinic has only one doctor twice a month. <https://www.groundup.org.za/article/vital-eastern-cape-clinic-has-only-one-doctor-twice-month/>
- Kalonji, D., & Mahomed, O. H. (2019). Health system challenges affecting HIV and tuberculosis integration at primary healthcare clinics in Durban, South Africa. *African Journal of Primary Health Care & Family Medicine*, 11(1), 1-7. <https://doi.org/10.4102/phcfm.v11i1.1948>
- Kane-Berman, J. (2014). From the last grave at Dimbaza to three tiny graves at Bloemhof. *Institute of Race Relations*. <http://irr.org.za/reports-and-publications/atLiberty/files/liberty-from-last-grave-at-dimbaza-to-three-tiny-graves-at-bloemhof>
- Khoza, A. (2018, June 26). NHI: Anaesthesiologists warn of a mass exodus of doctors if legislation is implemented recklessly. *News24*. <https://www.news24.com/SouthAfrica/News/nhi-anesthesiologists-warns-of-mass-exodus-of-doctors-if-legislation-is-implemented-recklessly-20180626>



- Lebese, L., Begg, K., Dudley, L., Mamdoo, P., Engelbrecht, J., & Andrews, G. (2018). Development of a national strategic framework for a high-quality health system in South Africa. *South African Health Review*, 2018(1), 77-85.
<http://www.hst.org.za/publications/South%20African%20Health%20Reviews/sahr2018.pdf>
- Maama, H. (2020). Institutional environment and environmental, social and governance accounting among banks in West Africa. *Meditari Accountancy Research*, 29(6), 1314-1336.
<https://doi.org/10.1108/MEDAR-02-2020-0770>
- Mail & Guardian. (2012, 30 November). *Standards to improve health care*.
<https://mg.co.za/article/2012-11-30-standards-to-improve-health-care/>
- Malakoane, B., Heunis, J. C., Chikobvu, P., Kigozi, N. G., & Kruger, W. H. (2020). Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC Health Services Research*, 20(1), Article 194.
<https://doi.org/10.1186/s12913-020-5037-6>
- Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1), a1902.
<https://doi.org/10.4102/curationis.v42i1.1902>
- Maseko, L., & Harris, B. (2018). People-centeredness in health system reform. Public perceptions of private and public hospitals in South Africa. *South African*.
- Medical Research Council. (2015). Saving Babies 2014-2016 – Triennial report on perinatal mortality in South Africa. Retrieved from
[https://www.westerncape.gov.za/assets/departments/health/napemmco triennial report 2014-2016 saving babies.pdf](https://www.westerncape.gov.za/assets/departments/health/napemmco%20triennial%20report%202014-2016%20saving%20babies.pdf)
- Michel, J., Obrist, B., Bärnighausen, T., Tediosi, F., McIntyre, D., Evans, D., & Tanner, M. (2020). What we need is health system transformation and not health system strengthening for universal health coverage to work: Perspectives from a National Health Insurance pilot site in South Africa. *South African Family Practice*, 62(1), 1-5.
- National Department of Health. (2013). Regulating the quality of health services: Benchmarking of approaches, institutions and systems. Towards the establishment of an Office of Health Standards Compliance (OHSC). Retrieved from
<http://www.dnaeconomics.com/assets/Usealexconstantinoudnaeconomicscom/OHSC-Regulating-the-Quality-of-Health-Services.pdf>
- Obuaku-Igwe, C. C. (2015). Health inequality in South Africa: A systematic review. *African Sociological Review*, 19(2), 96-131.
- Office of Health Standards Compliance. (2017). Annual inspection report 2016/17. Retrieved from
<http://ohsc.org.za/wp-content/uploads/OHSC-2016-17-ANNUAL-INSPECTION-REPORT-FINAL.pdf>
- Raborife, M. (2017, May 23). More than R1bn was paid in medical negligence payouts by Gauteng Health – DA. News24. Retrieved from <http://www.news24.com/SouthAfrica/News/more-than-r1bn-paid-in-medical-negligence-payouts-by-gauteng-health-da-20170523>
- Sogfa, F., Maama, H., Ojogiwa, O. T., & Mubangizi, B. C. (2022). Government communication in crisis: The priorities and trends in South Africa's response to COVID-19. *The Journal for Transdisciplinary Research in Southern Africa*, 18(1), 1-10. <https://doi.org/10.4102/td.v18i1.1146>
- Statistics South Africa. (2017). General household survey. Pretoria: Statistics South Africa.
- Stop Stockouts. (2015). 2015 Stock outs national survey. Retrieved from
http://stockouts.org/Download/2015_stock_outs_national_survey.pdf

- Wilson, L. (2018, 2 July). Dr. Aaron Motsoaledi is clueless – NHI cannot work in SA. News24. Retrieved from <https://www.news24.com/Columnists/GuestColumn/dr-aaron-motsoaledi-is-clueless-nhi-cannot-work-in-sa-20180702>
- World Health Organization. (2015). Tracking universal health coverage: First global monitoring report. *Geneva: World Health Organization*.
- Zille, H. (2018, March 22). Life Esidimeni the tip of an iceberg – What the Western Cape is doing to prevent another tragedy. News24. Retrieved from <https://www.news24.com/Columnists/HelenZille/life-esidimeni-may-be-the-tip-of-the-iceberg-what-the-western-cape-is-doing-to-prevent-another-tragedy-20180322>